WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia
Strengthening families & children within their home communities

Semi-Annual Progress Report

April 1, 2017 – September 30, 2017

West Virginia Department of
Health and Human Resources

Bureau for Children and Families

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Safe at Home West Virginia

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I. Overview

West Virginia was awarded our approval to proceed with our Demonstration Project, Safe at Home West Virginia, on October 14, 2014. Safe at Home West Virginia is high fidelity wraparound aimed at 12-17-year old's currently in congregate care settings in West Virginia or out-of-state and those at risk of entering a congregate care setting. West Virginia also plans to universalize the use of the WV CANS across child serving systems.

Recognizing the way we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

Safe at Home West Virginia Wraparound will help improve identification of a youth's and family's strengths and needs; reduce the reliance on congregate care and length of stay in congregate care; reduce the reliance on out-of-state residential care; improve the functioning of youth and families, including educational attainment goals for older youth; improve timelines for family reunification; and reduce re-entry into out-of-home care. The benefits of a wraparound approach to children and families include:

- One child and family team across all service environments;
- The family's wraparound plan unifies residential and community treatment;
- Wraparound helps families build long-term connections and supports in their communities;
- Provides concurrent community work while youth is in residential care for a smooth transition;
- Reduces the occurrence and negative impact of traumatic events in a child's life;
- Access to mobile crisis support, 24 hours per day, seven days per week; and
- Crisis stabilization without the need for the youth to enter/re-enter residential care.

As we begin to redirect funds from congregate care using a universal assessment and thresholds; changing our culture of relying on bricks and mortar approaches to treatment; and implementing wraparound to prevent, reduce, and support out-of-home care, we will free up funding to redirect into building our community-based interventions and supports. We will use the assessed target treatment needs from the WV CANS to guide our decision about the best evidence-informed treatment for the targeted needs at the community level and begin to develop a full array of proven interventions to meet the individual needs of children and families in their communities. This approach and model will lead to our children getting what they need, when they need it, and where they need it. It will also enhance our service delivery model to meet the needs and build on the strengths of the families of the children.

There are no significant changes in the design of our interventions to date.

Safe at Home West Virginia

Theory of Change

We implement CANS and NWI

So That

We have clear understanding of family strengths and needs

And

A framework/process to address those strengths and needs

So that

Families will receive the appropriate array of services and supports

And

Are more engaged and motivated to care for themselves

So that

Families become stabilized and/or have improved functioning

So that

Families have the knowledge and skills to identify and access community services and supports and can advocate for their needs

So that

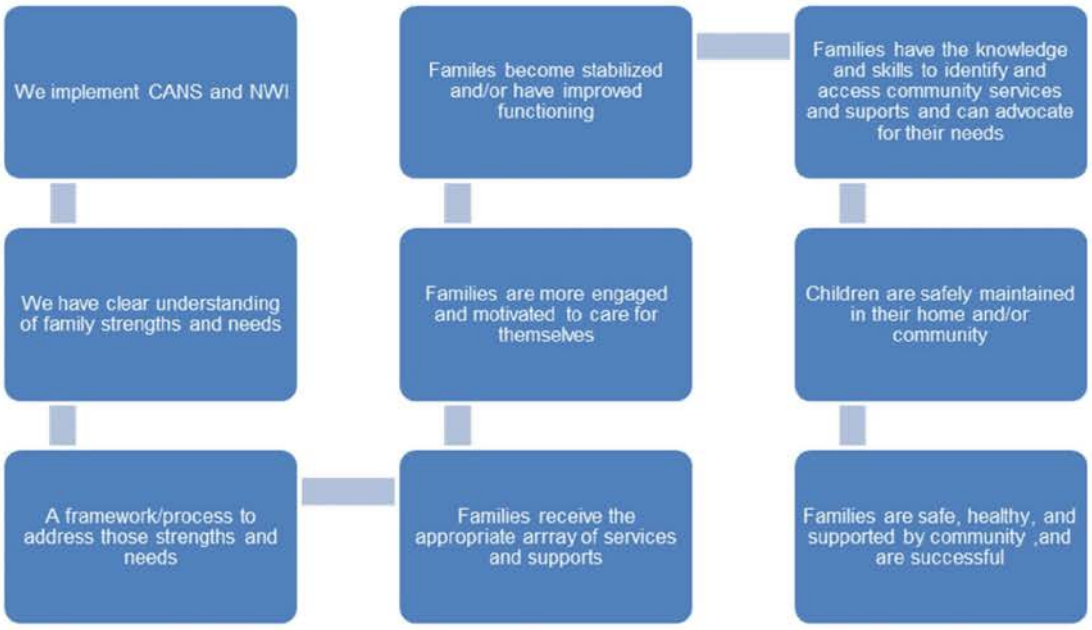
Children are safely maintained in their home and/or community

And

Families are safe, healthy, supported by community, and are successful

Safe at Home West Virginia

Safe at Home West Virginia Theory of Change



Safe at Home West Virginia

Safe at Home West Virginia Logic Model

Inputs	Interventions	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
• Youth 12-17 in open cases • Flexible funding under Title IV-E waiver • CAPS/CANS tools • Caseworkers trained in wraparound service provision • Multi-disciplinary team • Courts • Coordinating agencies • Service providing agencies	• CAPS/CANS assessments to determine need for wraparound services • Intensive Care Coordination model of wraparound services • Next Steps model of wraparound services	• Number of youth[1] assessed with CAPS/CANS • Number of youth and families engaged in wraparound services while youth remains at home • Number of youth engaged in wraparound services while in non-congregate care out-of-home placement • Number of youth engaged in wraparound services while in congregate care	• Compre-hensive assessments lead to service plans better aligned to the needs of the youth and their families • Delivery of services tailored to the individual needs of the youth and families results in stronger families and youth with fewer intensive needs	• More youth leaving congregate care • Fewer youth in out-of-state placements on any given day • More youth return from out-of-state placements	• Fewer youth enter congregate care • The average time in congregate decreases • More youth remain in their home communities • Fewer youth enter foster care for the first time • Fewer youth re-enter foster care after discharge • Fewer youth experience a recurrence of maltreatment • Fewer youth experience physical or mental/ behavioral issues • More youth maintain or increase their academic performance

[1] All references to youth in the logic model refer to youth in open cases who are between 12 and 17.

II. Demonstration Status, Activities, and Accomplishments

Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the 11 counties of Berkley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne with the first 21 youth being referred for Wraparound Facilitation. West Virginia also began the process of universalizing the CANS across child serving systems.

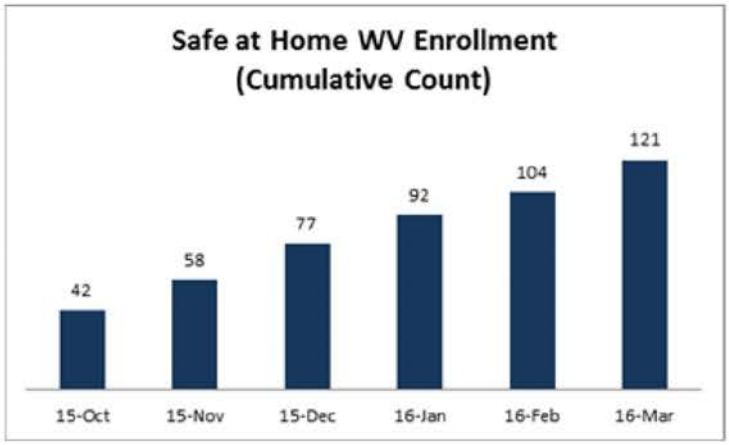
On August 1, 2016, West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker, and Upshur. This phase of implementation brought in counties from each of the 4 BCF regions.

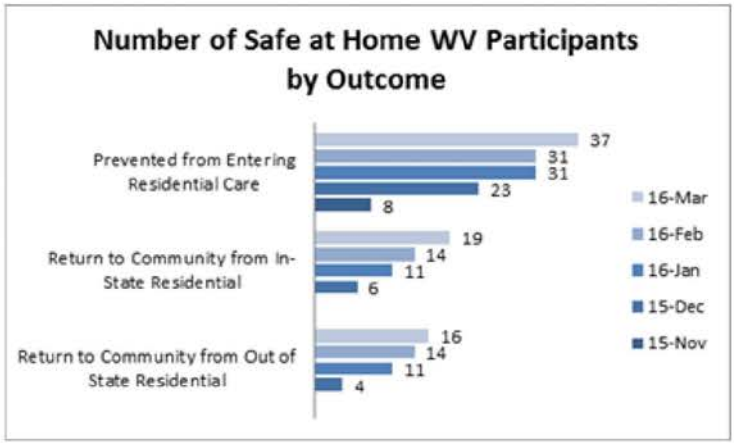
On April 1, 2017, West Virginia began Phase 3 of implementation by expanding to the remaining 20 counties of; Braxton, Clay, Jackson, Roane, Ritchie, Doddridge, Pleasants, Wood, Marshall, Tyler, Wetzel, Calhoun, Gilmer, Wirt, Fayette, Raleigh, McDowell, Wyoming, Mingo, and Webster. This phase brought the entire state into full implementation.

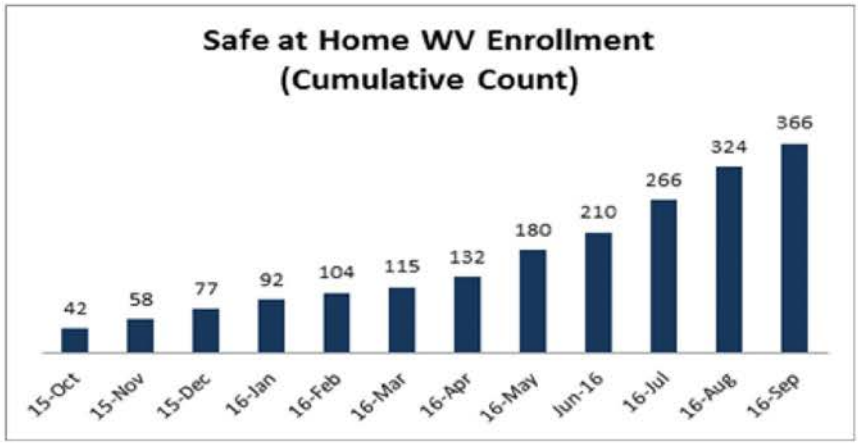
As of September 30, 2017, 1,172 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 58 youth from out-of-state residential placement back to West Virginia, 171 Youth have stepped down from in-state residential placement to their communities, and 15 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 713 at risk youth.

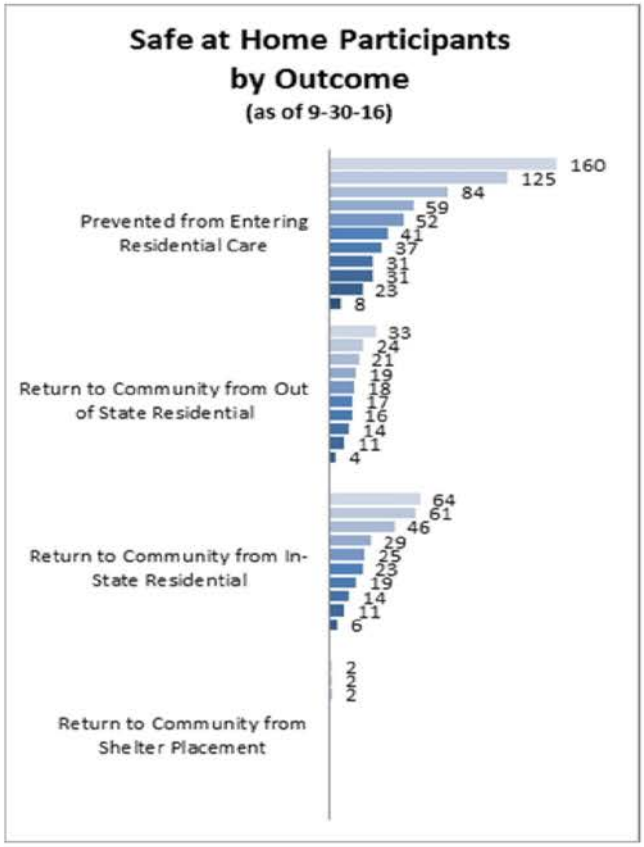
The breakdown of placement type at time of enrollment is as follows:

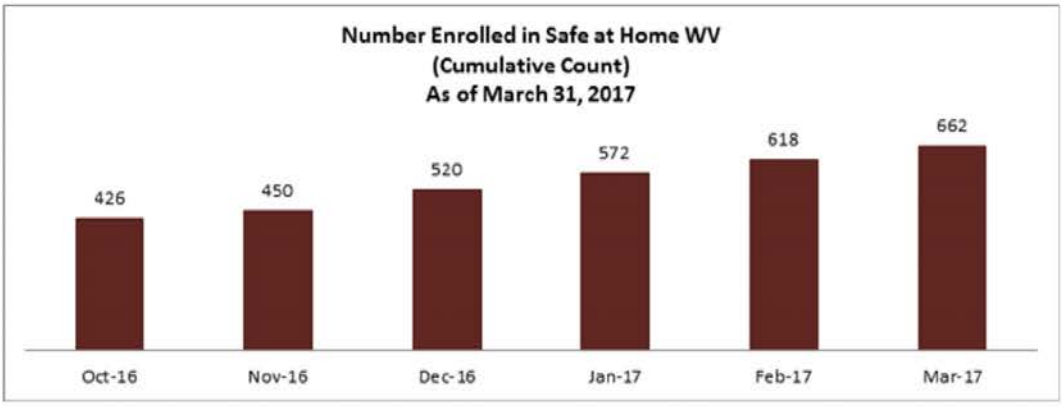
- 83 were or are in out-of-state residential placement at time of enrollment with 58 returning to WV
- 264 were or are in in-state residential placement at time of enrollment with 171 returning to community
- 789 were or are prevention cases at time of enrollment with only 76 entering residential placement
- 36 were or are in an emergency shelter placement at time of enrollment with 15 returning to their community

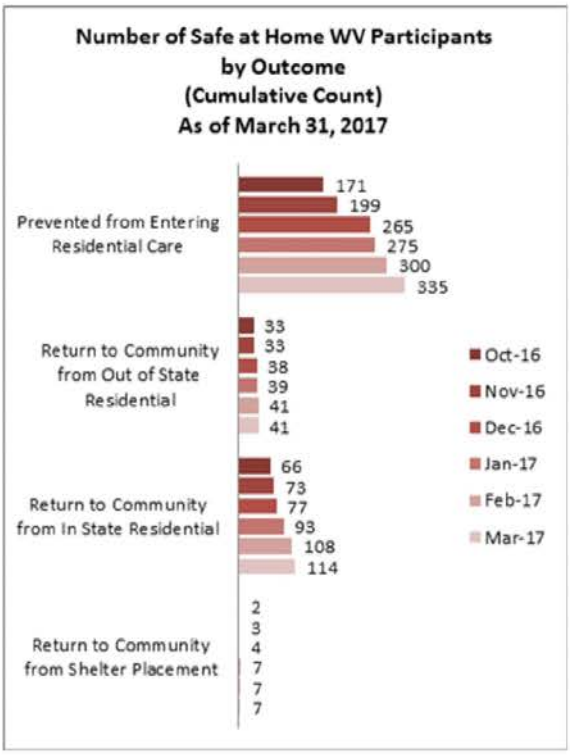

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
121
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar

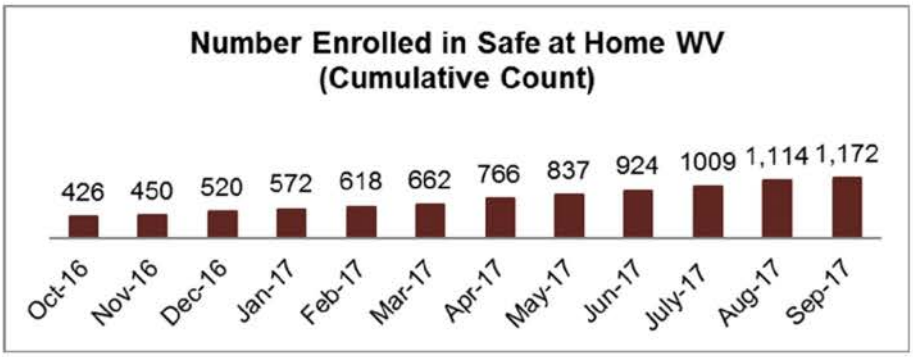

Number of Safe at Home WV Participants
by Outcome
Prevented from Entering Residential Care
37
31
31
23
8
Return to Community from In-State Residential
19
14
11
6
Return to Community from Out of State Residential
16
14
11
4
16-Mar
16-Feb
16-Jan
15-Dec
15-Nov

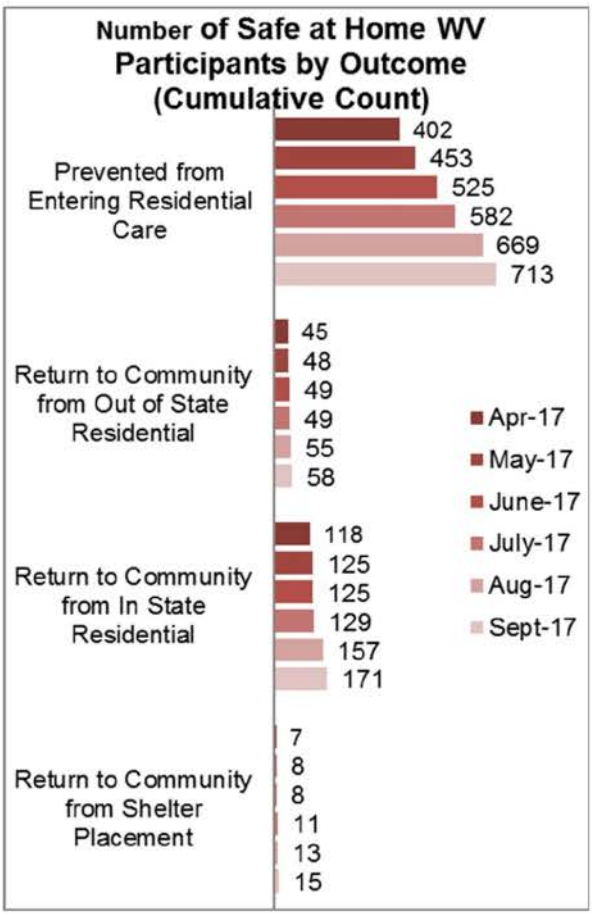

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
115
132
180
210
266
324
366
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep


Safe at Home Participants
by Outcome
(as of 9-30-16)
Prevented from Entering Residential Care
160
125
84
59
52
41
37
31
31
23
8
Return to Community from Out of State Residential
33
24
21
19
18
17
16
14
11
4
Return to Community from In-State Residential
64
61
46
29
25
23
19
14
11
6
Return to Community from Shelter Placement
2
2
2


Number Enrolled in Safe at Home WV
(Cumulative Count)
As of March 31, 2017
426
450
520
572
618
662
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17


Number of Safe at Home WV Participants
by Outcome
(Cumulative Count)
As of March 31, 2017
Prevented from Entering Residential Care
171
199
265
275
300
335
Return to Community from Out of State Residential
33
33
38
39
41
41
Return to Community from In State Residential
66
73
77
93
108
114
Return to Community from Shelter Placement
2
3
4
7
7
7
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17


Number Enrolled in Safe at Home WV
(Cumulative Count)
426
450
520
572
618
662
766
837
924
1009
1,114
1,172
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
July-17
Aug-17
Sep-17


Number of Safe at Home WV
Participants by Outcome
(Cumulative Count)
Prevented from Entering Residential Care
402
453
525
582
669
713
Return to Community from Out of State Residential
45
48
49
49
55
58
Return to Community from In State Residential
118
125
125
129
157
171
Return to Community from Shelter Placement
7
8
8
11
13
15
Apr-17
May-17
June-17
July-17
Aug-17
Sept-17

As part of our ongoing tracking and monitoring the Local Coordinating Agencies and the BCF Regional Social Service Program Managers turn in tracking logs that provide status updates on all cases. This also allows the identification of barriers to cases progressing.

Leading up to our first Safe at Home West Virginia referrals West Virginia developed a program manual and family guide as well as DHHR/BCF policies, desk guides and trainings. All staff and providers were provided with Wraparound 101 training, an overview of the wraparound process, Family and Youth engagement training that is part of our Family Centered Practice Curriculum, and CANS training. The West Virginia Department of Health and Human Resources (DHHR) instituted weekly email blasts that go out to all DHHR staff and our external partners. These email blasts focused on educating us on the 10 principles of Wraparound, family and youth engagement, and ongoing information regarding Safe at Home West Virginia. We also implemented a bi-monthly newsletter that reaches all of our staff and external partners, conducted presentations across the state as well as media interviews and private meetings with partners. These activities continue as specific to each phase of implementation and across the state. Our weekly email blasts and newsletters now reach over 1,000 partners. All program materials, newsletters, as well as other pertinent information are posted on our website for public viewing and use.

During the previous reporting period, West Virginia implemented the recommendations of our evaluator. This included the development of a professional white paper guiding the Local Coordinating Agency Clinical Supervisors in further professional development of the wraparound facilitators regarding engagement. BCF developed a similar transfer of learning process for use by Child Protective Service Supervisors and Youth Service Supervisors to assist the professional development of BCF staff regarding engagement. Our evaluator provided West Virginia with 4 case examples from the fidelity reviews they conducted during the previous reporting period. The 4 cases provided examples of successful case progression and outcomes that could be directly correlated to engagement. Those cases were used with staff during transfer of learning discussions. West Virginia continues with this recommendation to further develop and strengthen engagement skills.

Safe at Home West Virginia

During this reporting period, West Virginia has continued our work through the Local Coordinating Agencies to continue to build capacity to meet the needs of Safe at Home WV youth. LCA's have added mentors, therapists, and transportation aides in response to the service needs of clients. The Local Coordinating Agencies continue to work with their respective counties to build more external supports and services, especially volunteer services that will continue to partner with and support our families and youth as their cases transition to closure. This is often a challenge in rural communities but it is also exciting to see creative responses. One community organization came together to right a grant for public transportation to serve the larger community in their small rural area.

West Virginia has worked with the Capacity Building Center for States to develop a strategic plan to support the wavier as well as other BCF initiatives and needs. The Capacity Building Center for States provided a marketing consultant to assist with the development of a 1 page informational document about Safe at Home West Virginia. The document is written in layman terms and is being utilized by the department as well as any of our partners to inform and solicit community level support for the youth and families being served through Safe at Home West Virginia. This document is available for public use and may be accessed and printed from the Safe at Home West Virginia Website, safe.wvdhhr.org. West Virginia took this learned skill and updated the one page flyer to be more current and also developed a one page flyer for use to guide the community on identifying youth in the target population and who to contact for possible referral to Safe at Home West Virginia.

In July 2015, in preparation for Phase 1 implementation, the Bureau for Children and Families released a request for applications for Local Coordinating Agencies to hire and provide Wraparound Facilitators. The grant awards were announced on August 25th. The grants provided startup funds for the hiring of wraparound facilitators and to assure a daily case rate for facilitation and flexible funds for providing the necessary wraparound services.

The Local Coordinating Agencies could hire their allotted wraparound facilitators in 3 cohorts. West Virginia believed this would be the best process to use to assure their ability to hire and train their staff as referrals began to flow.

For Phase 2 implementation the Bureau for Children and Families released a request for application for Local Coordinating Agencies to hire and provide Wraparound Facilitators on February 26, 2016. The grant awards were announced on March 28, 2016. West Virginia adjusted the grant awards based on lessons learned from Phase 1 implementation and

required the Local Coordinating Agencies to hire their allotted positions prior to the implementation date. More time was allowed between the grant award date and the actual implementation of referrals to assure facilitators could receive required training.

This same process was followed in preparation of Phase 3 implementation. The same communication plan was implemented with staff and community partners. Case reviews and selection have followed the same process and referrals were prepared for implementation.

West Virginia held an "onboarding" meeting with the Phase 1 Local Coordinating Agencies on September 16, 2015, for the Phase 2 Local Coordinating Agencies on June 7, 2016, and for the Phase 3 Local Coordinating Agencies March 29, 2017 to assure consistency as we move forward. We then hold monthly meetings for the first 4 months and move to semi-monthly or quarterly. These meetings allow for open discussion and planning with regard to our processes and outcomes as well providing peer support and technical assistance among the agencies. Activities of this group include the updating of the wraparound plan form, updating the monthly progress summary, developing advanced training specific to the wraparound facilitation, working with our Grants division to update the monthly grant report to simplify reflecting performance measures and outcomes, and implementation of evaluation recommendations.

In preparation for Phase 1 implementation the local DHHR staff began pulling possible cases for referral for review and staffing during the months of August and September so that the referral process could go smoothly and the first referrals sent to the Local Coordinating Agencies on October 1, 2015. For Phase 2 implementation this same process was used during the months of June and July to prepare for the first referrals that were sent on August 1, 2016. For Phase 3 implementation this same process was used during the months of February and March for the first referrals to be sent on April 1, 2017. We found this process to work well and it has been used in preparation for all implementation phases.

The Phase 1 initial startup grant period of 1 year expired on August 30, 2016 and the Phase 2 initial startup grant period of 1 year expired on April 30, 2017. In preparation for this the Bureau for Children and Families prepared a provider agreement that includes all of the activities and requirements of the newest statement of work for Local Coordinating

Agencies and Wraparound Facilitation as well as the Results Based Accountability outcomes and performance measures that are outlined in the grants. All original provider agencies have signed the provider agreements to continue serving as Local Coordinating Agencies in their respective Counties.

CANS training and certification as well as Wraparound 101 training continue across the state to assure new staff hires have the required trainings. Both Wraparound 101 and CANS are now integrated into DHHR/BCF new worker training.

728 DHHR staff have been trained in CANS. 44 new Youth Service Workers have been trained. This ongoing training continues as planned.

During this reporting period 114 people have been certified or re-certified in the administering of the CANS.

West Virginia also continues with the identification and certification of WV CANS Advanced CANS Experts (ACES) to provide ongoing training and technical assistance. West Virginia is finding that staff are having difficulty accessing advanced CANS experts to provide technical assistance. In order to address this Dr. Lyons came to West Virginia and spent a week with another 13 staff identified to go through the advanced CANS experts process. He will also be providing ongoing technical assistance calls with the experts in order to continue the development process. The goal has always been to have the internal capacity within West Virginia to continue this process and the transferring of learning. We believe that with the assistance of the current experts and Dr. Lyons we will have no difficulty proceeding as planned. At present, we have 13 CANS experts with 7 providing certification training and the other 6 providing technical assistance.

West Virginia has also developed a plan for identifying all staff trained and certified, development of a training schedule based on identified need, technical assistance plan development based on identified need. Attached is the CANS Logic Model.

There are no significant changes in the design of our interventions to date but there have been innovations. During this reporting period, a group of Local Coordinating Agency Directors and Clinical Supervisors with extensive experience with Wraparound have worked to develop an advanced training for wraparound facilitators. We are referring to this training as "Applied Wraparound". At present the training is developed and has been piloted and is being

updated to expand to all facilitators. This training addresses better engagement with families, how to problem solve and move a team forward, how to better write wraparound plans with measurable outcomes, as well as other identified needs. It is to be more focused on the actual application and practice of wraparound facilitation.

We continue working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and possible trainings in using the MAPs process. MAPs refers to Making Action Plans. The training helps facilitators understand the MAPs process and details and how to conduct a MAP and integrate it into a Wraparound Plan.

During this reporting period, West Virginia has continued to follow the judiciary communication plan as developed last year. The plan simply calls for continued communication with our judiciary by combined teams of WV BCF management and LCA representation.

West Virginia also worked with our Evaluator, Hornby Zeller Associates, to create automated WV CANS. All appropriate DHHR staff and Local Coordinating Agency staff have been trained in the use of the automated WV CANS and have begun entering WV CANS and subsequent updates. West Virginia has been using the CANS since 2003. It has been updated to the WV CANS 2.0. WV CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the WVCANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; GLBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module. Staff continues to use the automated CANS and Local Coordinating Agencies continue to partner with the project director to assure that initial and subsequent CANS are complete on every youth enrolled in Safe at Home West Virginia.

Safe at Home West Virginia began implementation with the first referrals on October 1, 2015. The automated CANS data base did not become operational until February 12, 2016. During that time, there would have been cases that already transitioned to closure for various reasons. There has been a learning curve with the wraparound facilitators navigating the system and remembering to save changes to the document. This explains any discrepancy regarding the number of youth enrolled and the number of initial CANS completed in the system. The Safe at home West Virginia project director continues to work with the Local Coordinating Agencies to monitor and assure CANS are completed on each child being served.

At present 3,258 CANS have been completed and entered into the automated system. This number represents initial and subsequent CANS. CANS are to be updated at minimum every 90 days.

The system has proven to be very useful for the use of the CANS across systems. The ability for staff to quickly locate and use existing CANS is very helpful in treatment planning and the ability for administrative staff to access needed reports has proven to be very useful. We foresee this becoming even more valuable as West Virginia moves forward with the use of CANS in treatment plan development.

During this reporting period, the timeframe for completion of the initial CANS was changed from 14 days to 30 days. This change was made after comment by the Local Coordinating Agencies and staff during process evaluation interviews. BCF had already made this change to other provider agreement affecting programs in which CANS are administered so the change also brought consistency across all provider agreements and program structures. This change also required that all program manuals, matrix, and forms be updated.

Mentioned within West Virginia's Initial Design and Implementation reports is Senate Bill 393. This bill set forth very specific requirements regarding work with status offenders and diversion. West Virginia identified Evidence Based Functional Family Therapy (FFT) as a valuable service to the youth service population and their families as a diversion or treatment option. FFT is a short term (approximately four (4) months), high-intensity therapeutic family intervention. FFT focuses on the relationships and dynamics within the family unit. Therapists work with families to assess family behaviors that maintain delinquent behavior, modify dysfunctional family communication, teach family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. It is limited to youth 11-18 who have been charged or are at risk of being charged with either a status offense or a delinquent act.

West Virginia awarded a grant to a lead agency to facilitate service coverage and training throughout our state. Clinicians were trained and provide this valuable therapeutic service. FFT fits well within the wraparound process and has been identified as a very useful service for many of our families being served within Safe at Home West Virginia due to target population for FFT.

FFT is a well-established, evidence-based intervention model utilized in twelve (12) countries, including the United States. FFT has shown to reduce recidivism as much as 50%. It

is one of the many therapeutic options that are available to youth and a family that may be served by the juvenile justice system, child welfare, and Safe at Home West Virginia.

Regarding analyses; the evaluator will separate cases with FFT if the SACWIS system shows us whether the family got that service. If it does not, we can only obtain the information through our case readings and the prevalence of FFT will determine whether we get any meaningful information out of it.

To further assist us with moving forward with Results Based Accountability, the outcomes included within the Local Coordinating Agency grant agreement statements of work are connected to the outcomes for Safe at Home West Virginia. All contracts and Provider agreements include provisions for training other wraparound team members with specialized roles, such as Peer Support Specialist, Parent or Youth Advocates, Mentors, and all wraparound team members outside of the Local Coordinating Agencies, and adherence to clear performance measures for families utilizing Safe at Home Wraparound. These performance measure outcomes will be linked to continuation of yearly contractual relationships between the Bureau and each Local Coordinating Agency. Responsibility for executing the duties of the contractual relationship with the Bureau rests with the Local Coordinating Agency, as well as development of an inclusive network of community providers in order to ensure youth and families receive services that are needed, when they are needed, and where they are needed. We continue to work with our Local Coordinating Agencies to assure that their workforce development meets West Virginia's needs.

Prestera Center's Chief Executive Officer Karen Yost continues to provide Trauma-informed Care training to individuals representing all child serving systems and the community at large. This training provides an overview of the incidence and prevalence of childhood traumatic experiences and describes the impact that trauma can have on a child's physical, social, emotional, cognitive and behavioral development. Also discussed are trauma and the brain, the definition of trauma-informed care as a systemic framework around which services are developed and provided, and the six core components of a trauma informed system of care. Currently, Trauma-informed care is being redesigned to be required core training for all providers and BCF staff. Ms. Yost has also been conducting train the trainer sessions throughout the state to assist with expanding West Virginia's internal capacity to continue with this valuable training.

During this reporting period BHHF has fully implemented its Children's Behavioral Health Wraparound. In March 2016, the Bureau for Behavioral Health and Health Facilities (BHHF) released a Request for Applications for Grants for Local Coordinating Agencies to hire Wraparound Facilitators to serve 4 pilot areas of West Virginia. The BHHF pilot project is to provide high fidelity wraparound modeled after Safe at Home West Virginia, to children in parental custody and no involvement with the child welfare system. BHHF has worked closely with BCF to assure that the two programs are as similar as possible without overlap. Several of the pilot areas are part of the Phase 1 of Safe at Home West Virginia and all but 1 of the grant awards were to Local Coordinating Agencies that are also serving Safe at Home West Virginia. During the last reporting period, they had expanded to consider referrals from counties surrounding the original pilot areas. They have received a total of 112 referrals, 51 of those were accepted.

As discussed in West Virginia's Initial Design and Implementation Report we have worked with our out-of-home partners to make changes to our continuum of care. All provider agreements are being written to include performance measures. West Virginia continues to work with our partners to improve the continuum of care as well as our agreements.

As part of West Virginia's ongoing work to improve our continuum of care we have created a Treatment Foster Care model. As part of that process West Virginia has developed a Three-Tier Foster Family Care Continuum. This continuum includes Traditional Foster Care homes, Treatment Foster Care homes, and Intensive Treatment Foster Care homes. This was developed in partnership with the Licensed Child Placing Providers who currently hold the Treatment Foster Care grants.

During the previous reporting period, West Virginia developed a request for applications for lead agencies to develop Treatment Foster Care homes throughout the state. These grants were awarded to lead agencies in all 4 of the BCF Regions. During this reporting period, the three-tiered foster family care continuum was fully implemented.

Possibly most important is West Virginia's sustainability planning. Although sustainability has always been included within West Virginia's workplan the more focused activities to plan for transition out of the waiver began this reporting period. During this reporting period, a Finance workgroup comprised of the Project Director, BCF Deputy

Commissioner of Operations, BCF CFO, DHHR CFO and staff began meeting to determine necessary financial information that will be needed and used by other workgroups to inform any program adjustments. The financial planning also affords West Virginia the needed information to determine level of service and commitment needed to continue with this valuable program and to assist with the development of any needed improvement packages determined to be appropriate.

This group has requested Technical Assistance through Casey Family Programs which is scheduled during the next reporting period.

During this reporting period, West Virginia's evaluator has conducted the first full cost analysis that is included within this report. Our evaluator will be a valuable contributor to this group and financial sustainability planning as well as informing program adjustments.

III. Evaluation Status

Data Collection Activities:

During the most recent six-month evaluation period following implementation of Safe at Home West Virginia, the evaluator, Hornby Zeller Associates, Inc. (HZA), conducted the second annual fidelity assessment of local coordinating agencies (LCAs). HZA also re-administered the fidelity survey to Department of Health and Human Resources (DHHR) caseworkers, supervisors and county managers from Phase I implementation counties, and re-administered a separate fidelity survey geared toward LCA wraparound facilitators, supervisors and program managers. All of these data collection efforts were used to inform the process evaluation. Each is described in greater detail below.

Data from DHHR's Statewide Automated Child Welfare Information System (SACWIS), FACTS, were used to inform the outcome evaluation, along with data from the automated Child and Adolescent Needs and Strengths (CANS) tool and interview data regarding youth educational functioning. CANS and interview data were used to measure progress on well-being measures while data from FACTS were used to measure safety and permanency outcomes. All data collection activities are discussed in greater detail below.

Case Reviews and Interviews

As part of the fidelity assessment of Safe at Home, staff from HZA returned to West Virginia during the week of July 17, 2017 to conduct the second annual fidelity assessment. HZA completed case record reviews (Appendix B) for 40 cases across nine contracted agencies and conducted interviews with 79 key stakeholders (Appendix C). The count of cases reviewed at each agency was proportional to the number of youth served by the agency. The youth, a parent/caregiver, the LCA wraparound facilitator and the DHHR caseworker from each case were asked to participate in interviews. Some of the wraparound facilitators and caseworkers were interviewed about more than one case in the sample. Both the record reviews and the interviews were designed to provide information on the extent to which the program is being implemented in the way it was intended through the Safe at Home model. In addition to learning about fidelity, interviews were also

used as an opportunity to explore one aspect of child well-being, specifically, youth educational functioning. Table 1 displays the number of stakeholders interviewed during the summer of 2017.

Table 1. Stakeholders Interviewed by Group	
Youth	14
Parents/Caregivers	16
LCA Wraparound Facilitators	24
DHHR Caseworkers	25
Total	**79**

Surveys

A second round of fidelity surveys was administered to DHHR community service managers, supervisors and caseworkers from Phase I[2] implementation counties. Results from Phase II DHHR staff surveys were reported in the April 2017 semi-annual evaluation report. HZA staggers the administration of the DHHR staff survey to account for differences in staff training and time/experience working with the program. In addition to the DHHR staff survey, HZA administered a second annual fidelity survey to LCA Safe at Home program managers, supervisors and wraparound facilitators. Respondents provided their perceptions of the quality and effectiveness of services, what can be done to enhance them, the frequency with which they complete associated program responsibilities and the functionality of multi-agency collaboration.

On August 16, 2017, the survey link for the LCA staff survey was sent to the emails of all applicable LCA staff, using the online CANS database to identify applicable staff and their email addresses. HZA sent surveys to 155 staff persons. At least one LCA staff person from all but one agency participated in the survey.

On the same day, the survey link for the DHHR staff survey was sent to community services managers from all of the Phase I implementation counties, where all nine community services managers were asked to complete the survey and also to forward the

[2] Safe at Home's implementation rolled out in three phases. Phase I began October 1, 2015 and involved eleven counties, Phase II began August 1, 2016 and added 24 new counties and Phase III completed the statewide implementation on April 1, 2017 by bringing in the remaining 20 counties.

survey to their casework and supervisory staff involved with Safe at Home. The deadline to complete the surveys was September 1, 2017. Due to low participation rates, HZA extended the original survey deadline to September 15, 2017 and sent an updated message to stakeholders urging their participation. A total of seven DHHR staff and 51 LCA staff responded to the respective surveys.

FACTS Data

HZA uses data from West Virginia's FACTS to measure the impact on achieving the initiative's goals, e.g., reduced placement in congregate care. Outcomes for Safe at Home involved youth are compared to an historical comparison group of youth. The comparison groups, which are selected for each six-month reporting timeframe since the program was implemented, were selected from youth known to DHHR between State Fiscal Years (SFYs) 2010 to 2015. The characteristics of youth in each comparison group are similar to the youth in each of the three[3] treatment cohorts. A total of 1,058 youth have been referred to Safe at Home as of September 30, 2017.

Characteristics, including demographic data, case history, and program qualifying characteristics, such as involvement in mental health and juvenile justice systems, were used to match youth to the treatment group cohorts. Youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state congregate care facilities and group care, in-state congregate care facilities and group care, emergency shelter, family foster care placements and youth at home. The characteristics of the youth selected into the comparison groups are statistically similar to those in the corresponding treatment groups (Appendix D).

CANS Data

During the first few months of program implementation, HZA developed an online CANS tool for LCA and DHHR staff to use. The online CANS tool allows for ease of access and information sharing across participating agencies. Each youth who enters Safe at Home was originally expected to have an initial CANS assessment completed within 14 days of referral,

[3] HZA has not created the comparison pool for the most recent cohort but will do so for the next semi-annual evaluation period because not enough time has elapsed to measure outcomes for these youth. Therefore, six month outcomes will be available for the fourth cohort for the April 2018 semi-annual evaluation report.

and subsequent CANS assessments every 90 days. However, a policy change, which went into effect in June 2017, moved the 14 day initial assessment deadline out to 30 days, with subsequent CANS still to be completed every 90 days thereafter. This policy change was a direct result of process evaluation findings illustrating that LCA wraparound facilitators were struggling to conform to the 14 day initial CANS assessment deadline. The online CANS tool provides the evaluation team with ready access to assessment data which are used to measure progress on well-being measures.

IV. Significant Evaluation Findings to Date

Process Evaluation Results:

Youth Population Description

Table 2 provides a description of Safe at Home youth at the time of referral. Overall, 62 percent of the youth referred to Safe at Home were living in their own homes at the time of referral. Since Safe at Home was implemented, the percentage of youth in congregate care at the time of referral has continually decreased, giving rise to a more prevention based population. Youth placed in a congregate care setting at the time of referral comprised 56 percent of Cohort I youth and only 17 percent of those in Cohort IV.

Table 2. Safe at Home Youth Population Description				
	Cohort I	Cohort II	Cohort III	Cohort IV
Placement at Referral				
Total	**124**	**226**	**299**	**409**
Out-of-state Congregate Care	30	18	11	12
In-state Congregate Care	39	74	62	56
Emergency Shelter	5	18	6	13
Family Foster Care	2	11	13	27
Home	48	105	207	301
Age at Referral				
12 or less	10	20	26	35
13	20	26	35	60
14	30	51	66	75
15	28	59	66	121
16	32	64	93	100
17	4	6	13	18
Gender				
Male	77	116	189	250
Female	47	110	110	159

Table 2. Safe at Home Youth Population Description				
	Cohort I	Cohort II	Cohort III	Cohort IV
Race/Ethnicity				
White	96	184	250	364
Black	9	20	17	15
Mixed	15	19	26	14
Other	4	3	6	16

More males than females were referred to Safe at Home in each cohort; on average across all four cohorts, 63 percent of youth were males. However, fewer youth were male in Cohort II (51%). Additionally, gender disproportionality was highest among youth referred when placed in out-of-state congregate care, where males made up at least 75 percent of the population in each cohort. The majority of youth were white in all four cohorts (over 75%). The percentage of white youth increased slightly with each cohort.

Fidelity Assessment

As described above, the fidelity assessment was conducted during the summer of 2017 and HZA staff completed a total of 40 case record reviews on-site at the LCAs. The cases were selected randomly, in proportion to the number of youth served by each LCA. Ultimately, the case sample included cases from all four of the State's regions, and more specifically, the following 18 counties: Berkeley, Boone, Brooke, Cabell, Grant, Hardy, Jefferson, Kanawha, Lincoln, Mason, Mercer, Monongalia, Morgan, Nicholas, Ohio, Putnam, Randolph and Wayne. At the time of review, 26 of the 40 cases were open, eight had successfully graduated the program, and six were discharged before program completion. On average, the open cases had been open for 371 days as of the date the reviews were completed, while cases closed due to graduation were open 382 days and 223 days for discharged closed cases.

LCA Wraparound Facilitator Qualifications

LCAs are the contracted agencies with primary responsibility for delivering wraparound services to youth in Safe at Home, with one wraparound facilitator assigned to each youth in the program. Per the State's LCA funding announcements, wraparound

facilitators are supposed to have a Bachelor's Degree in social work, sociology, psychology or another human service related field and two years of work experience serving a youth population similar to that of Safe at Home's (i.e., ages 12-17 with a mental health diagnosis in congregate care or at risk of congregate care entry). Facilitators are also supposed to have a general knowledge of mental illness diagnoses and behavioral disorders in children, and personal family experience with mental illness is considered helpful. In some cases, the State will make an exception to one or more of these requirements if the applicant has extensive knowledge and/or experience in the field.

All 35 facilitators who responded to the survey reported having at least a Bachelor's Degree in one of the preferred human services fields, with the most common being in the field of psychology. Five of the facilitators also had a Master's Degree. Ninety-one percent reported having two plus years of experience in the behavioral health field. Seventy-one percent of facilitators had a prior knowledge base of mental illness diagnoses and behavioral disorders in children and 60 percent had personal family experience with mental illness.

LCA staff working with Safe at Home are also required to complete training, wraparound certification and CANS certification. According to the latest (Phase III) Safe at Home funding announcement, all LCA staff are required to have training which, at minimum, includes the following content:

- System of Care "Ladder of Learning" for Core Competencies,
- Child and Family Team Building,
- Family Centered Practice,
- Family and Youth Engagement,
- Effects of Trauma on Children and Youth,
- The 10 Wraparound Key Principles,
- Safe at Home West Virginia Model and
- BCF Policy Cross Training.

All 51 LCA staff who responded to the survey (inclusive of 35 wraparound facilitators and 16 supervisors) had received training prior to working with Safe at Home, and some had received multiple trainings. Only 14 percent of the respondents reported that the training they received did not prepare them sufficiently for the job. Eighty-nine percent of facilitators had received wraparound certification and all facilitators had received CANS certification. It

is possible that the small percentage of facilitators who had not completed the wraparound certification were new to the position and still completing the process.

Phase I: Engagement and Team Preparation

The first wraparound phase, Engagement and Team Preparation, is used to orient the family to the program and to begin engaging with the family and youth to explore their strengths, needs and goals; identify any pressing issues or concerns that the family has; and to build the wraparound team with an emphasis on family identified supports.

Interviewees reported that in most cases youth and their families initially learned about Safe at Home through their DHHR caseworkers. Typically, caseworkers provided a brief overview of the program to the families and their youth and how it may help to meet their needs. Following this introduction, wraparound facilitators provided a more in depth explanation of what Safe at Home entails. Some of the information wraparound facilitators reported sharing with youth/families include the program materials and associated paperwork, the team process of wraparound, how Safe at Home differs from DHHR, youth/family voice and choice, how assessments are used, the strengths based nature of the program, how the program benefits youth/families in general and the types of services that are available. In a few cases, youth/families first learned about the program through placement staff, the courts or the wraparound facilitator. In one case, the parent learned about the program on his/her own and requested to speak to a DHHR caseworker about Safe at Home and in a couple of cases youth already had a sibling currently in Safe at Home. One parent shared his/her takeaway of Safe at Home, stating, "Safe at Home is supposed to support us, be there for us during a crisis and provide services we can't get regularly. It does all this and more."

Wraparound facilitators and caseworkers were asked how well youth/families understood what the program entails. In all but three cases, facilitators and caseworkers believed that youth/families fully understood Safe at Home. One facilitator shared how s/he adapts to the youth/families learning styles to ensure they understand the program, stating, "[The youth] had to see it to understand it so I drew it out and showed [him/her] the systems on the outside and the family in the middle and how we were the linkage to all these services." In another three cases, it took time for facilitators to see that the youth/families really did understand the program. One caseworker shared of one of his/her experiences;

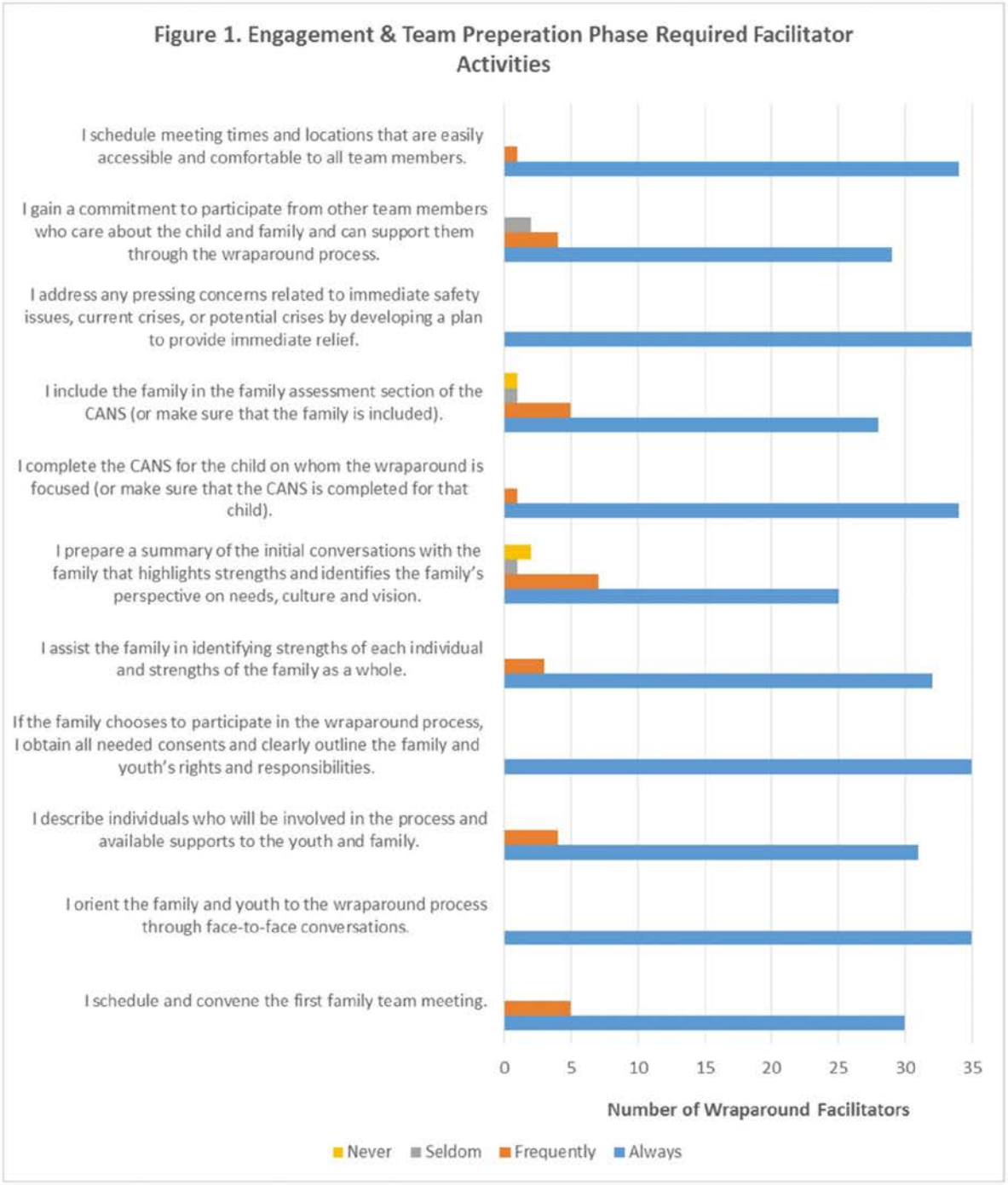
"They had a fair understanding, but I wouldn't say good. They didn't understand the level that the program could truly help. Once we began doing things, they got it."

Nearly all stakeholders interviewed reported that wraparound facilitators encouraged youth/families to share their concerns, hopes, goals or strengths in the very early stages of the case. Wraparound facilitators reported that in the majority of cases it took time to build rapport and get youth/families to fully engage with them and feel comfortable enough to share their concerns and goals. One wraparound facilitator shared a strategy for doing so, "I had the parents create a five year plan for [the youth] and [the youth] create a five year plan for [himself/herself], then we compared the plans. Together we mapped out where [s/he] is now and where we all wanted [him/her] to be." However, in some cases youth and families were able to share goals and concerns without much prompting or rapport building. A youth from one of these cases said, "When I met [the facilitator] I felt really comfortable right away and I just knew we would get along. I'm actually just going to be really sad when [s/he] has to go." In a few cases engagement continues to remain as an ongoing issue.

According to the interviewees, wraparound facilitators always asked youth/families to identify any supports they wanted to be involved with them through Safe at Home. However, most of the youth/families elected to keep Safe at Home involvement within the immediate family for a variety of reasons. In some cases, the youth/family did not have any supports they could identify and in others they did not want anyone else involved. Either way, facilitators often revisited this conversation throughout the life of the case. In eight cases, youth/families did identify supports and about half of those identified formal supports such as therapists, placement workers or school resource officers. The other half identified informal supports such as extended relatives, church members or friends. One facilitator provided an example where the youth wanted his/her aunts involved and, eventually, this opened up a placement resource for the youth.

Additionally, the LCA and DHHR fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during each phase of wraparound, including the Engagement and Team Preparation Phase. Due to the low response rate for caseworkers[4], only wraparound facilitator responses are included in Figure 1.

[4] Of the five caseworkers who responded, only three had any direct experience handling Safe at Home cases.



Nearly all wraparound facilitators surveyed reported completing each of the required casework activities "Always" or "Frequently" during the Engagement and Team Preparation Phase.

Phase II: Initial Plan Development

The purpose of the Initial Plan Development Phase is to create the initial wraparound and crisis safety plans through a collaborative team process. Youth/families are to play an active and integral role in planning, where their feedback is elicited and incorporated into plans wherever possible. This section of the report discusses who participates in the planning process, what resources are used and how quickly it happens. It also reviews the steps which go into making revisions to the initial plan and how frequently that is done.

Nearly all youth, parents, facilitators and caseworkers agreed that youth/family input is prioritized and incorporated into planning. Strategies employed by wraparound facilitators to involve youth in planning varied greatly. Facilitators worked with youth/families to develop long and short term goals, often through a brainstorming process. Facilitators asked youth/families to think about how they as a team can achieve these goals and what is most important to them. Sometimes the CANS was used as a discussion piece in the planning process to talk about areas of need and strength. Wraparound facilitators often laid out who is responsible for what parts of the plan. As time went on, the team would discuss progress and areas that still needed work. Facilitators would ask youth/families what they were doing well and whether they were following through with the actions necessary to achieve the goals.

Parents commonly noted that they provide feedback/input whenever necessary. They also help to make sure the youth and family members comply with the plan. Parents also reported they work to come to a consensus as a team in developing the plans and provide updates on youth progress and/or setbacks. One parent said, "We [mom and dad] did a lot with [the facilitator] to come up with a school solution that would work for [the youth] and the crisis plan." Most parents also reported that youth make substantial contributions to wraparound planning, with one saying, "Yes, most definitely. [The youth] is there for every meeting and [s/he] always asks a lot of questions and is always very interested with the planning." A few youth provided examples of instances where their input had actually been used in planning, such as expressing interest in particular activities, voicing their desire to consider an alternative learning environment and goal setting.

When it was difficult for wraparound facilitators to engage youth/families in the planning process, facilitators used multiple strategies to get them to participate. Examples of these strategies include adjusting planning activities to the unique learning styles of youth/families, convincing youth/families that LCAs are not DHHR or the courts, working around families' hectic schedules and finding times that are most convenient for them, looking to other supports for feedback when there is minimal participation by youth and families, offering suggestions, building rapport by showing that facilitators follow through, and figuring out what motivates each individual and offering incentives.

As a formal support/team member, caseworkers were asked to share how they assist in wraparound plan creation. Three of the 25 caseworkers interviewed reported that they have not been involved in wraparound planning at this point. For the majority who were, they stated that they provide input while allowing the facilitator to take the lead in planning. Caseworkers reported that facilitators share ideas to garner their feedback prior to the planning meetings; they also noted that their position allows them to provide thorough youth/family histories. Additionally, caseworkers stated that they help by utilizing their legal authority when necessary to sign off on service referrals for youth and follow up with providers to ensure that plans are being implemented. Nearly all caseworkers agreed that the planning process was very youth/family driven and saw their role as supportive in nature. One caseworker described the collaboration process with the facilitator, stating, "Usually [the facilitator] will contact me and let me know [s/he] is getting a new plan. We usually meet up in person and we will see what [the youth] needs, [his/her] goals, and we talk about what [the youth] needs at the time. As time goes on problems change and we work together to update plans accordingly."

Another tool used in planning is the CANS. Wraparound facilitators are responsible for completing CANS assessments for all youth in the program. As noted earlier, initial CANS are to be completed within 30 days of referral to Safe at Home while subsequent CANS are to be conducted every 90 days thereafter. When looking at the overall average, LCAs completed the initial CANS 36 days after referral and subsequent CANS every 90 days thereafter. Therefore, LCAs as a whole fell slightly short of fulfilling the initial CANS requirement but subsequent CANS were performed within the required timeframe.

While it may appear on the surface that LCAs are not meeting the required timeframe for initial CANS assessments, only one of the nine LCAs included in the fidelity assessment stood out as falling widely short on this measure. When this one LCA is excluded from the calculation, the remaining eight LCAs completed the initial CANS within 22 days of referral; exceeding the necessary timeframe by eight days. The LCA falling far short of meeting the initial CANS measure, also had two cases which were outliers, with initial CANS not being completed until 200 plus days following referral. When just those two cases are excluded from the analysis then the statewide average becomes 26 days following referral.

Wraparound facilitators shared how they use CANS assessments in planning, stating that CANS is used to identify areas of concern so the team can figure out how to address the youth and families' needs. Additionally, the CANS tells the facilitator how urgent each need is which helps with prioritizing. Facilitators also use the CANS to identify areas of strength on which they can continue to build and which they can use to address the areas of need. Often facilitators discussed CANS results with youth/families as a way to demonstrate progress, focus planning and develop or refine goals.

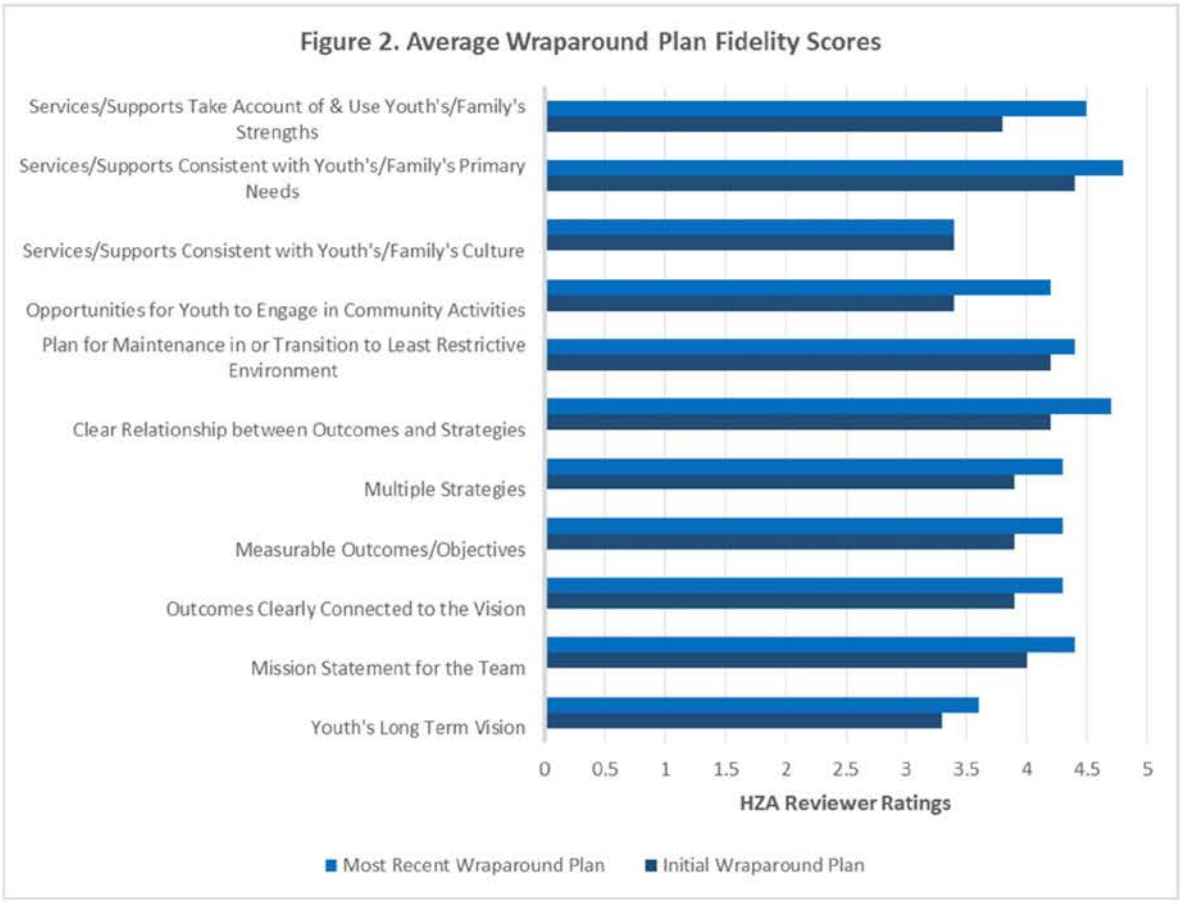
Stakeholders listed the goals that had been established through the Safe at Home planning process. While goals varied among the 40 cases, the most common responses included improvement in grades, behavior, school attendance, social skills and family relationships, and to achieve permanency when youth were placed out of the home. One youth exhibited exceptional motivation with goal planning, stating, "Once they leave, my personal goal is to do what I'm doing now, but be able to do it on my own without them."

Most youth and parents reported witnessing progress and/or goal achievement through their involvement with Safe at Home. One parent said, "If you could see how [the youth] was before and how [s/he] is now; [s/he] is a completely different person. [S/he] was always mad, anxious or depressed and [s/he] still has those moments, but we are seeing those moments less and less." One parent who did not believe his/her youth was progressing said, "[S/he] is just going to have to learn on [his/her] own that we're trying to help [him/her]."

Youth and parents also discussed what is currently being done to overcome challenges. Two youth reported that upcoming plans to change the school environment would help them in overcoming the challenges they continue to face in meeting some of their goals. Parents shared a variety of strategies that have been employed to help get youth back on track, such as collaborating as a team to come up with solutions, ensuring that placements are stable, making sure counseling attendance is high and medications are appropriate, and keeping on top of youth when it comes to school work and attendance.

Initial wraparound plans are to be completed within 30 days of program referral. On average, LCAs completed initial wraparound plans within 45 days of referral, falling short of this timeframe by 15 days. Subsequent wraparound plans are to be updated and refined as necessary, and on average they were revised every 50 days.

HZA reviewed the initial and most recent wraparound plans and rated the content for the extent to which required items were included in the plan. Reviewers used a five point Likert scale, with one meaning the item was "Not at All" a part of the plan and five meaning the item was "Thoroughly" included in the plan. Figure 2 displays the average scores for each fidelity item, showing comparisons between the initial and most recently completed wraparound plans.



All but one of the items showed improvement in the fidelity scores from the initial to the most recent plans; there was no change for the "Services/Supports Consistent with Youth's/Family's Culture" item. As LCAs learned more about the youth and their families and built a rapport with team members, they were able to conform better to the requirements of the Safe at Home model. It should be noted, however, HZA reviewers noted it was difficult to identify data on the families' cultural needs in the record. Overall, items were rated relatively high with no scores below a 3.3 at any point. The greatest degree of improvement was evidenced on the "Opportunities for Youth to Engage in Community Activities" item.

Initial crisis safety plans are also to be completed within 30 days of Safe at Home. On average, all LCAs completed the initial crisis plans within 39 days of referral, falling slightly short of meeting the required timeframe. Subsequent crisis safety plans are to be updated

and refined as necessary, and on average this occurred every 53 days. When the same agency which stood out as not meeting the required timeframe for initial CANS is excluded from the statewide analysis of initial crisis safety plans, the statewide average is 30 days, which meets the required timeframe for this measure.

Similar to its review of the wraparound plans, HZA reviewed the initial and most recent crisis safety plans to assess their thoroughness, again using a five point Likert scale to assess their completeness. Figure 3 displays the average scores for each item assessed, showing comparisons between the initial and most recently completed crisis safety plans.

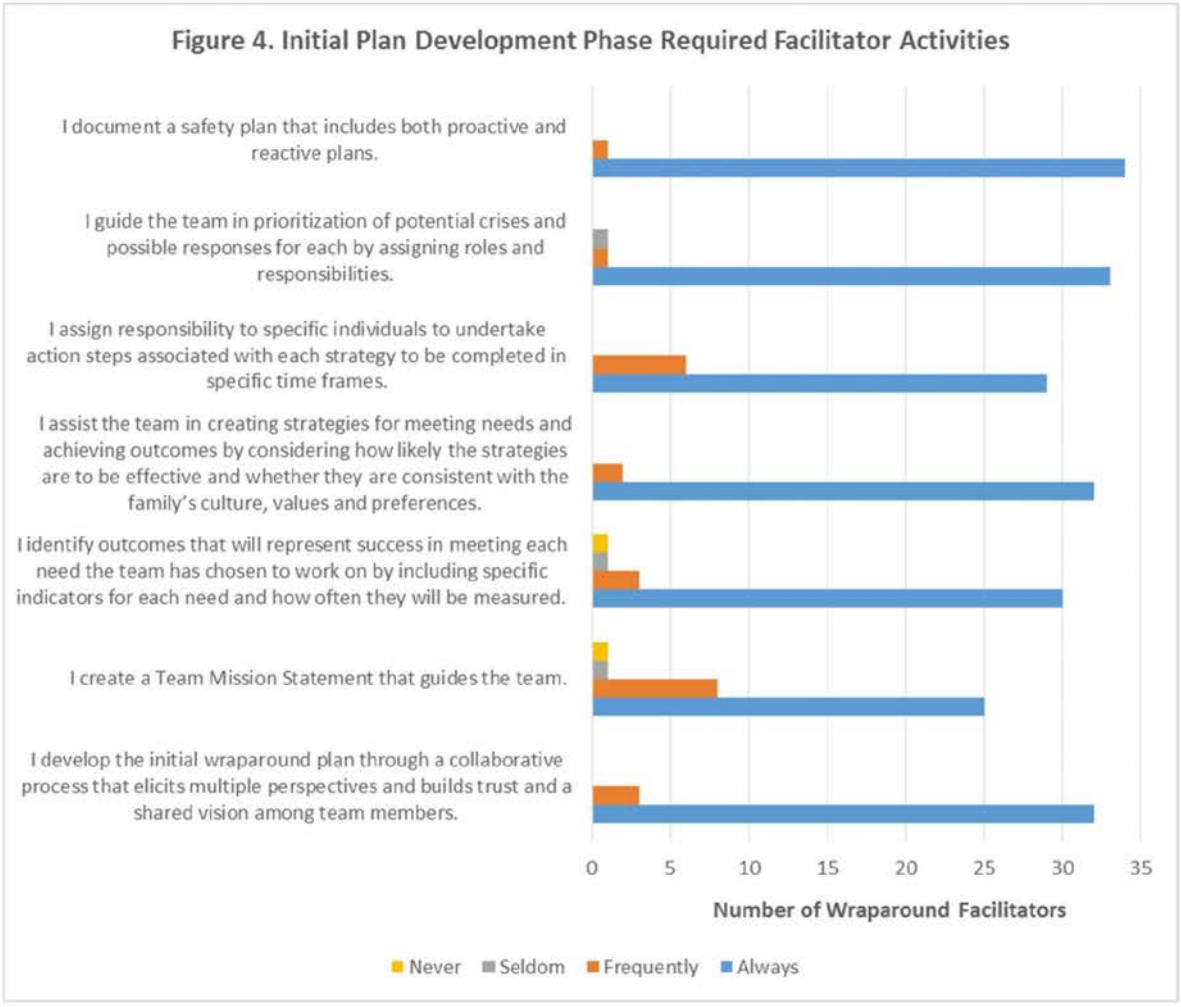
LCAs exhibited improvement on all items from the time of the initial to the time of the most recent plans, demonstrating that LCAs have improved in meeting crisis safety plan fidelity measures over time. The "Assignment of Roles During Crisis" item was rated the highest on both the initial and most recent plans. The "Identification of Behaviors Signaling Coming Crisis" item was rated the lowest on both initial and most recent crisis safety plans.

Caseworkers generally reported that their involvement was minimal in crisis safety planning and usually the wraparound facilitators took the lead and caseworkers provided their input when necessary. In only one instance did a caseworker state that they were not involved in crisis safety planning, and this was attributed to conflicts between the

caseworker and facilitator. Half of the youth could not remember anything about crisis safety planning and this

was also the case for three of the 16 parents. The remaining youth and parents all reported that they have been involved in crisis safety planning. Facilitators reported that youth/families were always involved in crisis safety plan development and refinement, but that plans were sometimes not implemented because youth never experienced a crisis.

The surveys of LCA and DHHR staff were also used to measure the extent to which required tasks were performed during the early stages of providing wraparound. Due to the low response rate for caseworkers, only wraparound facilitator responses are included in Figure 4.



Nearly all wraparound facilitators surveyed reported completing all of the required casework activities "Always" or "Frequently" during the Initial Plan Development Phase.

Phase III: Plan Implementation

The third phase of wraparound, Plan Implementation, is when the wraparound plan is put into action. It also offers an opportunity to revisit and update plans whenever necessary, to ensure that the youth/family and team members remain engaged, to continually monitor progress and address any challenges as they arise, and to celebrate successes.

Wraparound facilitators are required to have weekly contact with youth/families to

start and then gradually reduce contact as progress is being made and youth/families get closer toward transition; all stakeholders reported that this was occurring. In cases where youth had graduated the program, stakeholders reported the visits were gradually reduced from weekly to biweekly and then to monthly contact. Most interviewees agreed that the amount of contact between wraparound facilitators and youth/families was adequate. However, in a couple of cases stakeholders across the board believed that the frequent contact was too overwhelming/invasive for the youth/family. In two cases, facilitators stated that the contact was not frequent enough but that the youth/families consistently cancelled meetings.

All stakeholders were asked to share both the formal and informal services that youth/families have received during their participation in Safe at Home. Services were tailored to meet the needs of youth/family and as one caseworker reported of the wraparound facilitator's flexibility and creative service planning, "[S/he] makes referrals, finds placements, takes [the youth] out to do things, [s/he's] just a support for [the youth]. Anything I need [s/he] helps me with. [S/he] has found [the youth] non-formal support systems of people that will be good for [him/her] like a mentor. [S/he] helps us in getting [the youth] clothes or any other basic needs. Anything [the youth] needs, [s/he] is willing to do or get." Services varied due to different needs and/or goals. The ten most common services received included:

- individual therapy,
- tutoring,
- school advocacy,
- family therapy,
- life skills,
- youth coaching,
- medication management,
- community outings,
- mentoring and
- parenting classes.

Caseworkers and facilitators were evenly split as to whether or not service barriers were an issue with the cases reviewed. The greatest barrier they cited was the lack of

consistency by the youth/families and follow through or motivation to succeed. In a few cases placement changes/disruptions resulted in services stopping and starting, which could be a challenge as well. In two cases, disputes between the caseworker and facilitator made it difficult to come to an agreement about what services would be best for the youth. The most common responses as to which services were lacking included placements for teenagers with mental health needs, mentoring programs, medication management, adolescent psychiatry and services for youth with special needs.

Facilitators provided examples on ways they have worked to overcome the challenges caused by service barriers such as: making lots of calls; physically being there to make sure youth/families follow through; staffing the case with LCA supervisors, DHHR staff and school staff; rewarding youth for participation; working to keep placements stable; looking for informal mentors; and tele-conferencing with doctors or getting them to prescribe for months out.

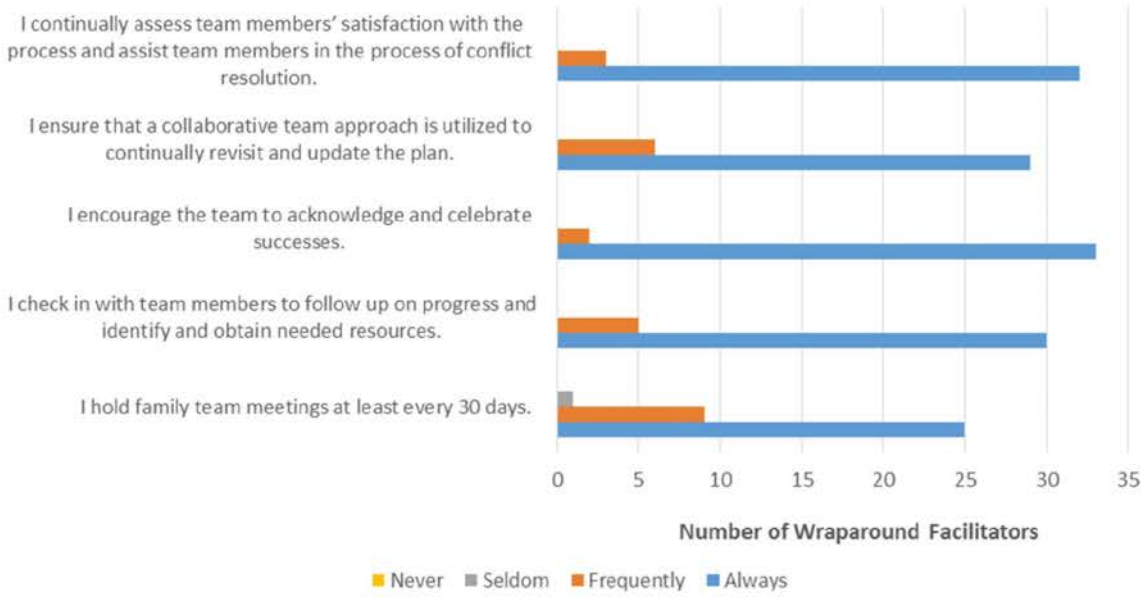
Nearly all stakeholders reported that wraparound facilitators identify and/or reward the success that youth achieve, and facilitators stated that determining the best reward comes down to figuring out what motivates each individual. In two cases, youth reported the facilitator does not recognize their success but also stated that there has not been much, if any, success at this point any way. Some of the most common rewards for youth received from facilitators were trips out to eat, specific gifts the youth wanted or needed, going out to participate in fun activities, verbal praise/acknowledgment and going to the movies. Stakeholders also reported successes youth have achieved. A few of the more frequent responses included improvements in the following: behavior, grades, school attendance, family relationships/communication and social skills. Wraparound facilitators monitored case progress in a variety of ways, such as through frequent contact with youth/families, provider reports, the CANS, monthly progress reports on the case and monthly wraparound team meetings. When youth/family progress was stunted, one caseworker said, "If [the facilitator] sees they are struggling [s/he] calls me and we do a home visit together and try to see what's going on and remind the family that we need to make progress and see what's going on so we can get back on track."

Caseworkers, youth and parents reported that in most cases wraparound facilitators were diligent and, for the most part, successful in getting youth to make active decisions in ongoing planning activities. For example, one caseworker said, "[The facilitator] engages [the youth] by keeping the dialogue open with the youth, getting them to speak about their

future, their hopes and dreams. [The youth] wants to be a nurse, so the facilitator got [him/her] tutoring, helped [him/her] find programs for college and getting a nursing/LPN/assistant nurse certification - all of this came from [the youth] as the program went on." In the remaining few cases where youth were not active in planning, caseworkers reported that facilitators made substantial efforts to engage youth in service planning, but engagement was a challenge due to parental issues, lack of motivation or interest from the youth and youths' serious mental health issues.

Here too, the fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during this phase of wraparound. Based on the low response rate for caseworkers, results for the wraparound facilitators are only included in Figure 5.

Figure 5. Plan Implementation Phase Required Facilitator Activities



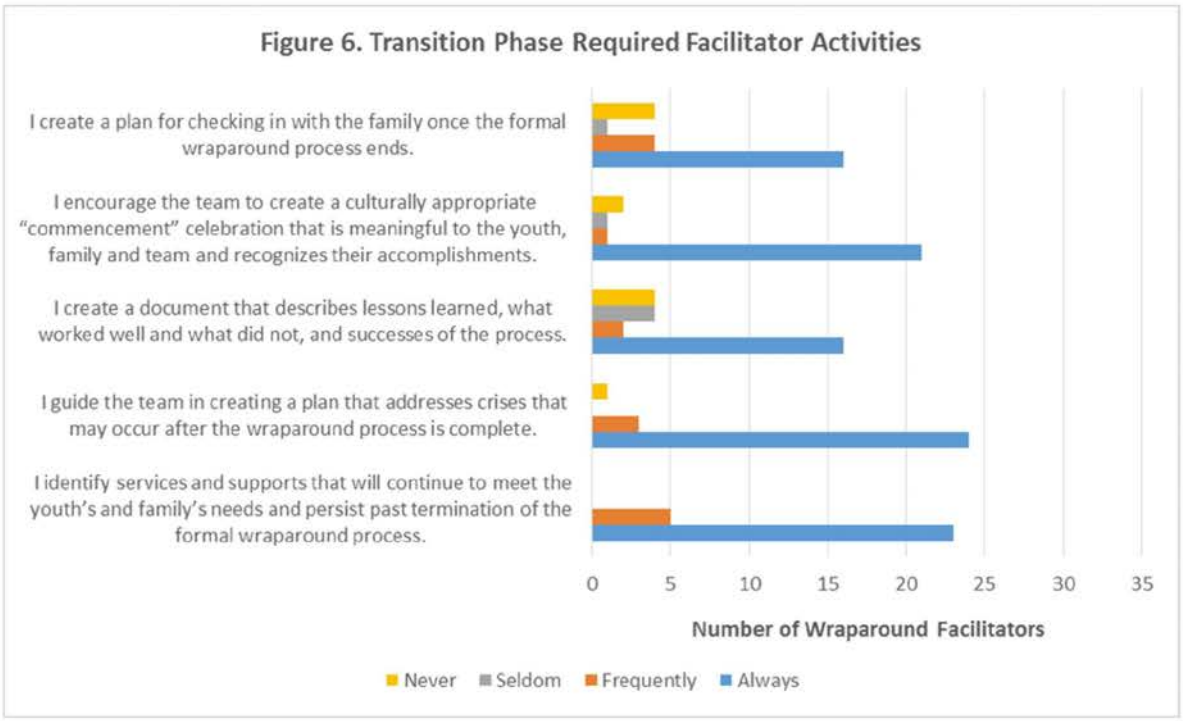
Nearly all 35 wraparound facilitators who responded to the survey reported completing all of the required casework activities at a frequency of "Always" or "Frequently" during the Plan Implementation Phase.

Phase IV: Transition

The purposes of the Transition Phase are to plan for the end of wraparound services when the team's goals and objectives have been met, to conduct a commencement or some type of ritual to celebrate success and to formally discuss where the family can go for help in the future.

Of the 14 closed Safe at Home cases in the sample, eight had successfully graduated the program, and thus, completed the Transition Phase. Stakeholders from the eight completed cases reported that the team knew the youth was ready to graduate Safe at Home because all the goals set forth had been achieved. All interviewees stated that facilitators held some sort of celebration for youth/families to symbolize graduation from the program. Often times gifts were given to the youth and in a couple cases scrap books with pictures of the journey were also given. Youth, parents and facilitators stated that at the celebration the group discussed the youths' achievements and the progress they made throughout the life of the case. In five of the eight cases, wraparound facilitators gave youth a diploma/certificate, and in a sixth case the facilitator gave the youth a closing letter listing all of the successes. All stakeholders reported that the wraparound facilitator provided the youth/family with information on where to go for help in the future should it be necessary. In most of the cases, the wraparound facilitator offered themselves as a resource should issues arise in the future.

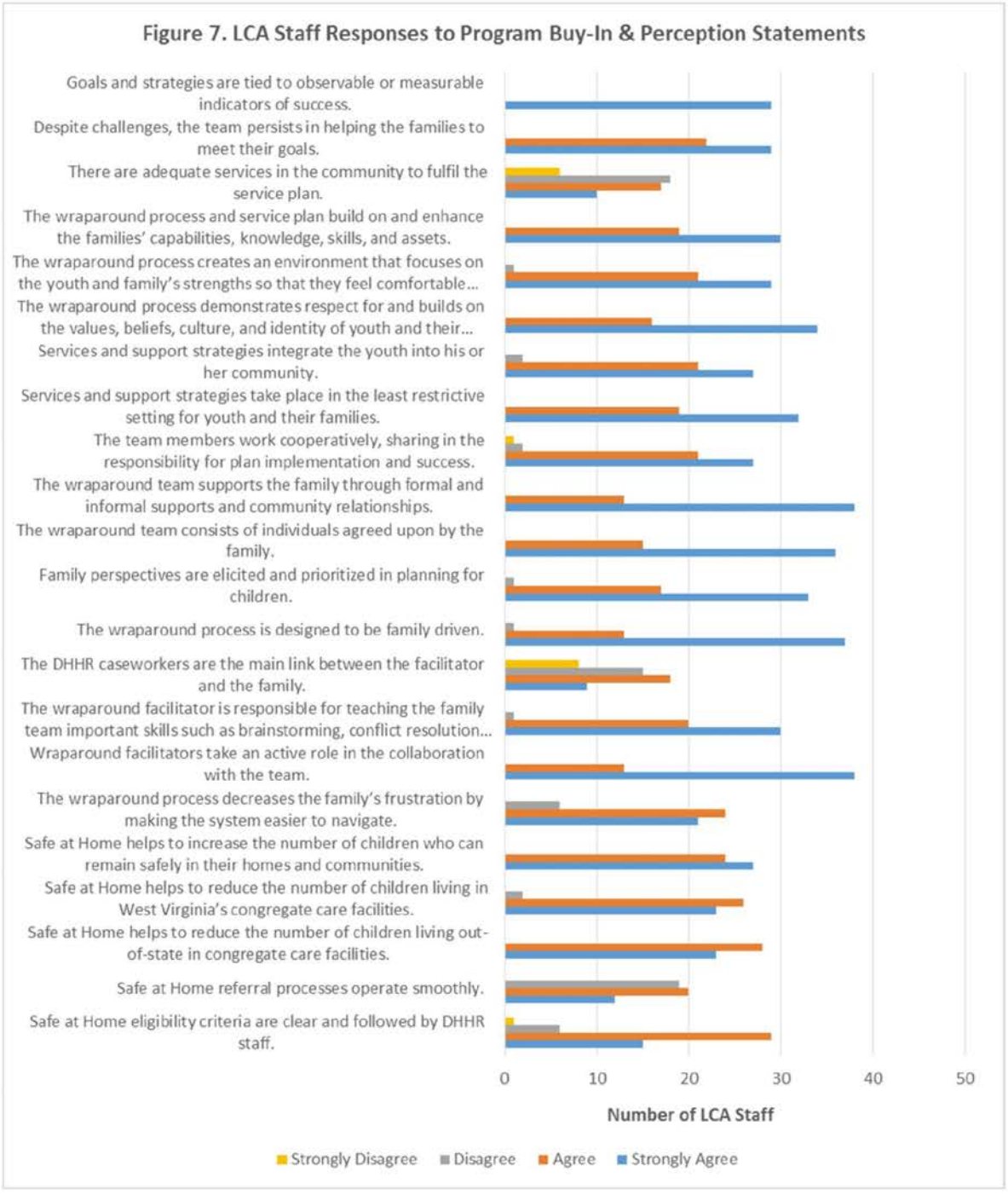
LCA and DHHR fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during each phase of wraparound. Results are limited to the surveys completed by wraparound facilitators, as displayed in Figure 6.



Compared to facilitator responses of required casework activities for the first three phases of wraparound, required activities are not being completed as regularly for the Transition Phase. For example, just over half (51%) of the facilitators responded that they "Always" or "Frequently" created a document that described lessons learned, what worked well and what did not, and the successes of the process. It is particularly concerning that only 57 percent of the facilitators "Always" or "Frequently" created a plan for checking in with the family once services end.

DHHR and LCA Staff Program Buy-In

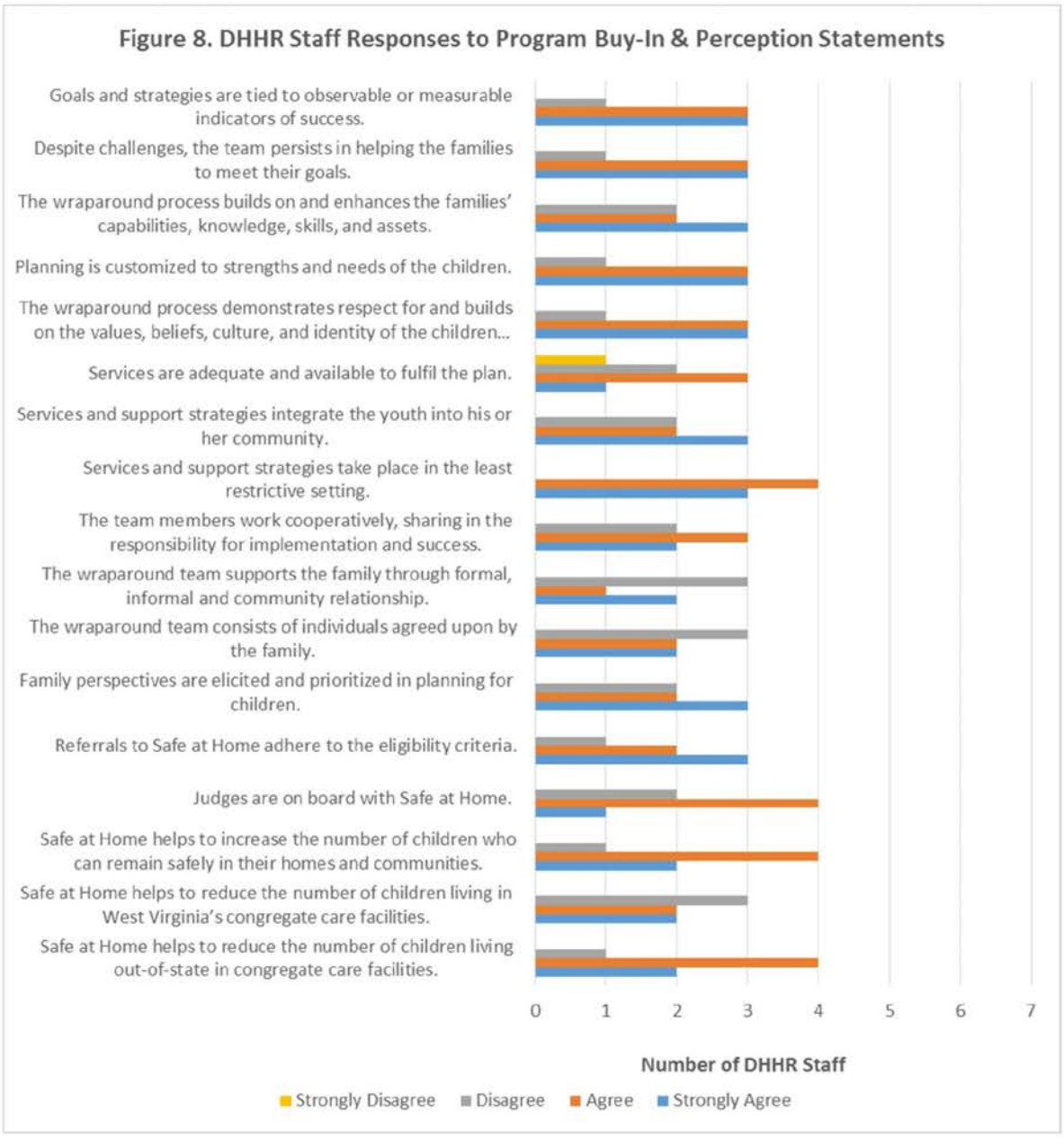
In addition to the questions regarding fidelity, LCA and DHHR staff who participated in the survey were asked about the extent to which they agreed with statements regarding their buy-in to Safe at Home and also generally, their perceptions as to whether or not Safe at Home's implementation has gone as planned. Figure 7 represents the responses to those statements asked of LCA staff.



Overall, LCA staff buy-in and perceptions of program success were relatively high, with most statements eliciting "Strongly Agree" or "Agree" responses. There were two items

which stand out as not following this trend as they received very mixed responses. First, only 53 percent of LCA staff believed there were an adequate amount of services in the community to fulfill service plans. The second item was related to DHHR and LCA teamwork, where only 53 percent of LCA staff believed caseworkers were the main link between the facilitator and the family.

Figure 8 provides similar feedback from the perspective of DHHR staff.



DHHR staff responses indicate relatively high buy-in for Safe at Home and positive overall perceptions of the program. Similar to LCA staff, DHHR staff held mixed views as to whether or not services were adequate and available to fulfill service plans.

Successes and Challenges

Interviewees were asked about the various successes and challenges that occurred with the 40 cases selected for review as well as any suggestions for program improvements.

Facilitators and caseworkers provided examples of what has worked well for the 40 cases reviewed; Table 3 offers the opportunity to review the extent to which their responses were similar as well as how they differed.

Table 3. Most Common Facilitator and Caseworker Perceptions of Case Success Factors

Facilitator Responses (most common to least)	Caseworker Responses (most common to least)
Youth/Family Voice and Choice	Relationship Between the Youth and Facilitator
Youth/Family Motivation to Succeed	Proactive and Persistent Facilitators
Consistency and Flexibility of the Facilitator	Extra Support of the Facilitator
Changing the School Environment	Team Collaboration and Effort
Re-evaluating and Changing Approaches	Youth/Family's Motivation to Succeed
Low Turnover of the Formal Support Team	Thorough Insight into the Youth/Family

Caseworkers' three most common responses in regard to factors which contributed to case success with Safe at Home were all about the diligent work of facilitators. One caseworker said, "I think that the amount of time spent by the facilitator with [the youth] contributed to the success of [his/her] program. In general, I think that the Safe at Home program works because there is an extra person on-site at the youth's home and school, interacting with the family and not having caseworker responsibilities, so the facilitators spend time connecting to the youths, and this is what really makes the difference. They see firsthand what the needs are, and have the resources and time to get the needs addressed." Wraparound facilitators' two most common responses were about the contributions of the youth/family in making the case successful.

All youth reported that Safe at Home has been helpful to them. A few youth reported that if not for Safe at Home, they would likely be in placement. All parents reported positive overall impressions of the program with one stating, "It's good to have the support. In West Virginia, whenever anything happens, the only solution DHHR gives you is for your child to go into state custody, because you can't get services and help unless the state has custody. This is weird. Like you can't get help unless you give up everything? Safe at Home gives support and services without giving up custody and sending your kid away."

Nearly half the youth and most of the parents reported that having the extra support of the wraparound facilitator was the best part of Safe at Home. Other program favorites shared by youth were getting involved in the community, finding a placement that was a good fit, crisis planning and learning social skills. Parents shared what they liked the best about Safe at Home and this included the use of creative and flexible services, the nonjudgmental engagement of youth/families and facilitators' willingness to try new services when progress is stalled.

Caseworkers and wraparound facilitators mostly agreed about what some of the most difficult challenges were with Safe at Home cases. The five most common responses were: youth/family engagement; youth behavior, serious mental health issues or trauma recovery; family conflict or problems with the home environment; poor placement choices; and obtaining services for youth/families.

Nearly all youth agreed that the program does not need any changes or improvements, but two youth did report that it can be overwhelming to have so many service providers involved at once. Parents' suggestions for program improvement ranged greatly, but a couple reported that ensuring facilitators' have excellent communication skills and that opening up the program to younger kids were areas that could be addressed.

Wraparound facilitators' most common recommended change for the program included better/faster communication from caseworkers. One facilitator suggested that a solution to the communication barrier might be in giving facilitators more legal decision making authority/power so they would not be at the mercy of getting ahold of caseworkers. The second most common recommended change for Safe at Home from wraparound facilitators was that the caseload of ten is too high. One facilitator suggested that the State should implement a caseload tier system so that those with more difficult cases are assigned fewer.

Caseworkers' three most common answers when asked what could be done to mitigate the challenges faced were finding more positive peer influences for youth, finding ways to ensure youth consistently attend therapy and better engagement skills which may aid in figuring out how to motivate youth to want to be successful.

Summary of Process Evaluation Results

Overall, LCAs did well with conforming to the requirements of the Safe at Home model and improvements were also noticed over time in wraparound and crisis safety planning. However, one area where multiple LCAs fell short was in meeting the required timeframe for completing initial wraparound plans. Additionally, one agency in particular did not meet the required timeframes for initial CANS assessments or crisis safety plans by a large margin and when this agency was excluded from the analysis, it was demonstrated that the remaining eight LCAs did in fact meet these timeframes.

In spite of wraparound facilitators' consistent efforts to get youth/families to identify natural supports, the vast majority of youth/families did not want others involved or did not feel as though they had any natural supports available to involve. In the few cases where supports were identified, half of them only included a formal support system. One of the key tenets of wraparound is in building and maintaining a strong natural support system so that when Safe at Home, DHHR and other formal supports leave, the youth/family will still be able to maintain their success without reliance on formal supports and systems.

The three most common goals youth/families had were improvements in grades, behavior and school attendance. Stakeholders also reported that these were also the areas in which the greatest level of success has been witnessed, indicating that Safe at Home teams are working hard to ensure youth achieve the goals set forth, and they are actually accomplishing what they have set out to do.

The five most common challenges shared by facilitators and caseworkers were: youth/family engagement; youth behavior, serious mental health issues or trauma recovery; family conflict or problems with the home environment; poor placement choices; and obtaining services for youth/families.

Outcome Evaluation Results:

Youth Cohort Analysis

Between the start of Safe at Home and September 30, 2017 1,058[5] youth statewide

[5] The numbers of youth reported by HZA and the State may differ slightly because the State utilizes weekly tracking logs and HZA relies on quarterly FACTS extracts for data. Delayed data entry also contributes to small changes in the numbers of youth reported per cohort in each semi-annual evaluation report.